Society Reports.

NEW YORK NEUROLOGICAL SOCIETY.

April 4, 1899.

The President, Dr. Frederick Peterson, in the chair.

ALCOHOLIC NEURITIS IN A CHILD.

Dr. George W. Jacoby presented a boy, four years and a half old, exhibiting symptoms of alcoholic paralysis. When first seen on February 20, it was stated that the boy had been well up to four weeks previously, at which time he had had severe colic without vomiting or constipation. Then the left knee-joint had become swollen. Eight days previously he had been noticed to be unsteady in walking. It was found that the boy had received about a half to one tumblerful of beer daily ever since the age of six months. Examination had revealed extensor paralysis of the hands and legs, with a reaction of degeneration in all the muscles. The extensors of the thighs were unaffected, and there was no sensory disturbance. The speaker quoted some recent statistics regarding the habitual use of alcohol in a large German city. The municipal authorities had undertaken an investigation among the school children, and had found that of 100 children, 16 drank no milk. Twenty-five per cent. of the children had never tasted brandy, but had habitually drunk beer or wine. Eight per cent. had received their daily portion of brandy "to make them strong." He thought there was an almost equally large percentage of children among the German and Irish population here who were habitually given alcoholic drinks. This case emphasized the cumulative effect of small doses of a poison long continued.

Dr. William M. Leszynsky agreed thoroughly with Dr. Jacoby regarding the prevalence of this vicious habit in this country.

Dr. Joseph Collins said that he had two such cases under observation in the last two years. One of these, a child of seven years, was now passing through the second attack. This child had been in the habit of drinking beer. He had not completely recovered his muscular power when the second attack came on. Dr. Collins had been impressed with the phenomenon presented by all the cases that he had seen, and which was present in the case just exhibited, *i. e.*, the remarkable pallor of the cutaneous surface as compared with the redness of the mucous membranes. In this connection it was interesting to note that Hughlings Jackson had recently recorded himself again in favor of treating chorea entirely by the use of port wine.

Dr. Frederick Peterson remarked that it was very unusual for an alcoholic neuritis to be free from sensory symptom

Dr. Jacoby said that there was intense pain over the nerve trunks in his case, but there was no general hyperesthesia of the skin.

AN EPILEPTIC PATIENT WITHOUT AN ATTACK FOR FOUR YEARS.

Dr. J. Arthur Booth presented a woman, fifty-one years of age, as a case of cured epilepsy. The interesting point was that she had gone four years without an attack. She had been under his care since 1882. She had enjoyed good health up to the twelfth year, when she had had her first seizure, characterized by loss of consciousness, frothing at the mouth, biting the tongue and deep stupor. From this time up to 1880 there had been about six attacks each year. For the next two years the seizures were more frequent and severe, so that they occurred several times a week. The attacks were apparently not influenced by menstruation. She had been given bromide of sodium and chloral. At one time she had received as much as four drams of the bromide in the twenty-four hours. During the past year she had only taken ten grains daily.

Dr. Peterson remarked that in view of the investigations of Dr. Sinkler it did not seem proper to call any case of epilepsy cured, although ordinarily a case that had gone as long as four years without an attack might be considered as cured. A collective investigation on this subject would prove very instructive. Probably a much larger percentage was cured by drugs than by surgical operation.

Dr. Edward D. Fisher said that children often had attacks for several years, and then there was an interval of four years or more before their return. He had known cases to pursue such a course with little or no treatment, and hence it was not even presumptive evidence of a cure. He had not found anything to take the place of the bromides, and considered this the proper treatment. In his experience the continuous use of the bromides had not had any deleterious influence on the mind.

Dr. George W. Jacoby said that one must place some limit to determine what should be called a cure. An epileptic patient might have a return of his trouble just as he might of other disorders. An interval of many years followed by a return of the seizures he would rather look upon as a fresh attack of epilepsy brought about quite possibly by the same cause as had originally produced it.

Dr. L. Pierce Clark said that he had known several cases of epilepsy to apparently undergo a spontaneous cure, that is, they would have no seizure for perhaps thirty years, and this, too, without any apparent relation to medicinal or dietetic treatment.

Dr. Booth said that the result of drug treatment in epilepsy depended very largely upon the faithfulness with which the treatment was kept up, and it was because patients were usually negligent that more so-called cures were not reported.

TWO CASES OF LOCALIZED SCLERODERMA.

Dr. George W. Jacoby presented two women showing localized scleroderma. Both upper extremities and the face were affected in both persons. One patient, a girl of seventeen years, had been quite sickly in infancy. At the age of two years she had been scalded from the shoulders to the waist. At the age of five years stiffness of the hands had been first noticed. The other patient was thirty-five years of age, and had been a healthy child. She had been married at the age of twenty-two years, had had six healthy children, and had herself enjoyed good health. Seven years ago she had noticed a sore on the tip of the index finger of the left hand, and this had healed very slowly. Then the other fingers became the seat of open sores, and as they healed the fingers were noticed to be stiff. On examination, both patients presented hardness, stiffness and bronzing of the skin, together with wasting. There was an absence of the first phalanx of each finger. These cases were presented because of their comparative rarity. He had only seen three other cases. In two of the latter there had also been a history of scalding or of severe injury of some kind to the skin. He was inclined to think that these cases might not be tropho-neuroses, as was generally believed, but instead examples of parasitic infection. Both of the patients presented had been under treatment with the desiccated thyroid, one of them sufficiently long to show that the treatment was in her case an utter failure. The question always arose as to the possibility of this affection being dependent upon some interference with the function of the hypophysis.

Dr. B. Sachs said that about two months ago he had seen a gentleman who had fallen off a ladder, and in doing so one hand had been penetrated by a sharp steel wire. Soon after this accident there had been flushings connected with a part of the distribution of the musculo-spiral nerve. Subsequently a very marked and typical scleroderma had developed. The man had been under treatment with the thyroid, and was taking at the present time fifteen grains, three times daily. Under this medication the scleroderma had been distinctly diminished.

Dr. L. Stieglitz said that he believed he had been the first one in New York city to use the thyroid treatment in cases of scleroderma, and he had found that it was very beneficial during the hypertrophic stage. It was not surprising that in the stage of atrophy the method should prove unavailing. He had seen good results from this treatment in three cases.

Dr. Jacoby thought that localized scleroderma was different from the other forms of scleroderma—it was a distinct entity.

PROGRESSIVE MUSCULAR ATROPHY (?).

Dr. L. Stieglitz presented a man, sixty-two years of age, who six years ago had first noticed a weakness in the left leg. This had increased steadily, and had been associated with wasting. Two years ago he had been injured in a runaway accident, and asserted that he had been unconscious for a week. The pupils reacted to light and during accommodation. There was perfect control of the sphincters. Examination showed marked weakness and wasting of the left thigh and calf, and beginning wasting on the other side. The knee-jerk was absent on the right side, and on the left there was only a response in the sartorius muscle. The man also had a dislocation upward of the left hip. The case suggested three diagnoses. The first of these was tabes with a Charcot joint in the left hip, but it was evident that there was no disturbance in the sensory part of the arc, and there was no other symptom of tabes. The second possible diagnosis was dislocation of the hip with secondary wasting of the muscles, but, according to the history, the atrophy of the muscles had begun long before the injury to the hip. The third diagnosis, and the one to which he inclined, was progressive muscular atrophy with incidental dislocation of the hip.

Dr. L. Muskens said that in this case he had found a lack of faradic response, more marked on the left side. As a result of his examination of the patient he took the same position as Dr. Stieglitz.

Dr. Joseph Collins said that the case had been under treatment at his clinic for a long time, and there had then been no suspicion of the existence of progressive muscular atrophy. In the hospital in which he had been previously there had been no history given of muscular atrophy prior to the injury to the hip. He looked upon the case as one of dislocation occurring in a man of very feeble recuperative power. The atrophy seemed to be entirely one of inactivity.

Dr. Leszynsky thought that this patient presented remarkable resistance power in his extensors, and the condition of the knee-jerk seemed to him to point to tabes.

Dr. Fraenkel said that the fact that the knee-jerks were lost on both sides would indicate a more serious condition than an inactivity atrophy. The resistance of the extensors could be explained by contracture of the muscles as a result of the injury to the hip.

Dr. Stieglitz opposed Dr. Collins' diagnosis as not being in accordance with the conditions found in the two lower extremities. Gowers had stated that the knee-jerk was often lost before there was marked atrophy in cases of progressive muscular atrophy. The response from the sartorius seemed to indicate positively that part of the sensory arc must be free.

DEMONSTRATION OF SPECIMENS FROM A CASE OF ERYTHROMELALGIA.

Dr. B. Sachs and Dr. A. Wiener gave this demonstration. Dr. Sachs said that this disease had been carefully studied in the past six or seven years. The only autopsy on record was on a case under the care of Auerbach, and it was associated with tabes. There were changes found in the lumbar and sacral roots, but it was not shown that the ervthromelalgia was dependent upon central disease. Mitchell and Spiller had recently observed a case in which it had seemed to them that the nerves were more involved than the blood vessels. The specimens demonstrated had been taken from a man, thirty-six years of age, who had been first seen in 1898. At that time, when the part was pendent a few minutes, there was a violet color of the foot and ankle, associated with severe pain and tenderness. A few months later a gangrenous ulcer formed on the dorsum of the foot. There was marked atrophy of the anterior tibial group. Owing to the rapid spread of the gangrene, it had been considered necessary to amputate through the thigh. According to Weir Mitchell there was no gangrene in cases of erythromelalgia, and the disease was asymmetrical, but in this case the appearance had been typical before the occurrence of gangrene, and moreover slight gangrene had been reported by others. Marked arterial changes were found in this case, particularly in the larger branches of the popliteal artery. This in itself seemed to be a sufficient justification for Dr. Gerster's opinion that the amputation should be done above the knee. The symptoms seemed to be explained by obliterating endarteritis. The changes in the nerves were so slight that he looked upon them as secondary. It was interesting to note in this connection that several cases of cardiac disease and marked arterial sclerosis were at the Montefiore Home presenting the principal symptoms of erythromelalgia. There was an interesting analogy between erythromelalgia and Erb's description of intermittent claudication.

Dr. A. Wiener said that specimens of nerve, skin, muscle and connective tissue had been given to him for examination, and in not a single one were the arteries normal. Only in the distal portions of the peripheral nerves could any distinct changes be found, and they were rather degenerative than inflammatory. In all of the specimens a very prominent feature had been the enormous quantity of connective tissue. He had not been able to find a single case on record in which arterial changes had not been found, whereas cases had been reported in which there had been no changes in the nerves.

Dr. Ira Van Gieson thought that in this case the vessels were affected to a somewhat greater extent than in the Mitchell-Spiller case. The specimens showed plainly the predominance of the arterial changes.

Dr. C. L. Dana said that this case differed essentially from the typical ones described by Weir Mitchell in the occurrence of gangrene, and hence it was possible that the histological appearances were not exactly those found in the classical cases of erythromelalgia. Two cases of erythromelalgia were cited in which the urine had contained sugar, and the patients had improved greatly under appropriate dietetic treatment. This seemed to suggest that there might be an underlying diabetic or gouty state leading to neuritis or disease of the blood vessels.

Dr. William H. Thomson spoke of cases of pseudo-erythromelalgia occurring in Graves' disease, and in allied cases characterized by persistent tachycardia. He had seen at least ten of these cases, and felt sure that when severe they might be very readily confounded with true erythromelalgia.

Dr. Leszynsky remarked that two years ago he had seen a case of acromegaly in which erythromelalgia had attacked the upper extremities.

Dr. Stieglitz spoke of a case of typical erythromelalgia which he had seen about two years ago in a drug clerk. After a few months attacks of local asphyxia, associated with severe pain, had developed in the toes. Under rest in bed and the use of the iodides the improvement had been decided. Aside from the features mentioned all the classical symptoms described by Weir Mitchell had been present, yet if the case had been allowed to go on unchecked he was confident that gangrene would have developed.

Dr. Sachs, in closing, insisted that the case had been a typical erythromelalgia for several months, and that the gangrene had developed at a very late stage. The fact that it occurred in a man of thirty-five years, apparently healthy in every other way, was very interesting. The man had recovered very satisfactorily from the amputation, and the pain had entirely disappeared.

REMARKS ON TWO CASES OF BRAIN TUMOR, WITH PRESENTATION OF SPECIMENS.

Dr. Joseph Collins reported these cases. The first was that of a child of six and a half years. When four years old there had been an attack of measles, followed by slight otorrhea on one side. The last illness had been ushered in by severe headache and persistent vomiting, and the latter had lasted for about three months. Relief had been sought chiefly because of the intense pain and the trembling in the hands. Examination showed that the patient did not use the left hand as freely as the right. There was no control over urination and defecation. There was double choked disk. The diagnosis of cerebellar tumor, probably vermicular, was made. The strabismus which was present was not constant. The temperature was elevated from one to five degrees during the last few days. The autopsy revealed a lobulated mass, the size of an English walnut, projecting from between the hemispheres of the cerebellum. It had caused atrophy of portions of the right hemisphere of the cerebellum. The gross appearance of the tumor was that of sarcoma.

The second case was that of a woman, twenty years of age, who had been in good health up to November, 1897, or about seven months before coming under his observation. The initial symptom—intense pain all over the head—had appeared very abruptly, and had been associated with vomiting and dimness of vision and progressive dementia. The left eye showed distinct choked disk; the right eye great swelling of the veins. Three days after admission to the hospital an attack of syncope occurred. She was six or seven months pregnant. One month later she became restless and irritable, and developed fever. Labor was induced, but the patient died the next day.

The autopsy revealed a sarcoma the size of a hen's egg in the anterior third of the right lateral ventricle. Both ventricles were distended with fluid.

TEMPORARY (EXHAUSTIVE) PARALYSIS IN EPILEPSY.

Dr. L. Pierce Clark presented a brief abstract of his paper on this subject. An analysis of the cases therein reported was as follows: Cases of local exhaustion with general seizures; cases of paralysis at the beginning, and becoming, to a certain extent, permanent; exhaustion paralysis in infantile cerebral palsy; exhaustion paralysis associated independently with cerebral palsy, but on the opposite side to the organic lesion; cases of exhaustion manifested in aphasia only; cases of paralysis manifested in the right leg and left arm. His conclusions were: That the theory of exhaustion paralysis had been conclusively proved by physiological experimentation, and that exhaustion paralysis, generally localized to the parts participating in the spasm, was confined to those parts most convulsed in general seizures. There might be exceptions to this general rule. The transient paralyses might, after a time, become permanent hemiplegias. Temporary exhaustion paralysis was essentially exhaustion of cerebral centers, and the frequency or severity of the muscular spasm was not a fair index of the amount of exhaustion of these centers. A careful study of exhaustion phenomena suggested that epilepsy was clearly allied to paralytic states, due allowance being made for the fact that the epileptic brain did not possess the normal capacity. The great frequency of epilepsy as a symptom following most cerebral lesions of a transient nature tended to substantiate the clinical hypothesis of the close association of epilepsy and paralysis. Minute disseminated patches of sclerosis in different areas of the epileptic brain had been repeatedly demonstrated by various observers, and this also helped the hypothesis very strikingly. In not a few instances he had produced apparent epileptic seizures by massage.

Dr. Dana said that the photographs presented in connection with this paper gave a more graphic description of the epileptic convulsion than any others he had seen. They should prove very helpful to teachers. He thought when neurologists were able to make a closer study of the clinical phenomena of epileptic seizures they would be in a better position to localize the disorder.

Dr. I. Van Gieson said that the theories of epilepsy were not thoroughly satisfactory, and one of the advantages of a place like the Craig Colony was the opportunity afforded for close and prolonged study. He predicted that in these cases evidence of an abnormal expenditure of energy in the cortical motor cells would be found. In one case that he had studied, that of a patient who had been in the City Hospital, and had had sixty seizures in one day, unmistakable evidences existed of the expenditure of energy in the ganglion cells. He thought the metaplasm granules were the hitherto unrecognized evidence of this expenditure. In inveterate cases of epilepsy these granules would be found in the interior of the nerve cells and elsewhere.

Dr. Peterson said he had seen two or three cases of hemiplegia coming on during epileptic attacks, and they had been permanent.

Dr. Clark said that he had seen about forty cases of exhaustion paralysis in which the duration of the paralysis had varied from forty seconds to two or three weeks.

109. LÄHMUNG DES TRIGEMINUS UND ENTARTUNG SEINER WURZELN INFOLGE EINER NEUBILDUNG IN DER GEGEND DES GANGLION GASSERI; BEITRAG ZUR FRAGE NACH DER TROPHISCHEN BEDEUTUNG DES TRIGEMINUS (Paralysis of the Trigeminus and Degeneration of its Roots in Consequence of a Neoplasm in the Region of the Gasserian Ganglion, etc.). Jarl Hagelstam (Deutsche Zeitschrift für Nervenheilkunde, Vol. 13, Nos. 3 and 4, p. 205).

Hagelstam compares his findings in a case of endothelioma of the base of the brain, causing complete destruction of the Gasserian ganglion, with those in a similar case reported by Homen in 1890. Hagelstam found important changes in the cells of the sensory and motor nuclei of the fifth nerve, and some alteration in the large cells of the cerebral root of this nerve. The sensory root and the spinal root were much degenerated. The retrograde degeneration of the cerebral root, and the alterations in the large cells near this root, were regarded as evidence of the motor function of these structures. The paralysis of the peripheral motor and sensory branches was complete, taste was lost on the anterior part of the tongue on the side corresponding to the new growth. The sense of smell on this side was also altered. The paresis of the soft palate, the impaired hearing, the changes in the pupil, and the paresis of the facial muscles, observed by Hagelstam, could not be attributed to the destruction of the Gasserian ganglion, as the tumor was quite large and involved more than the fifth nerve. The case shows that hemiatrophy of the face is not dependent on lesions of the fifth nerve, and that trophic fibers are not contained in this nerve.

SPILLER.